The areas of distribution of the auriculo-temporal and infraorbital nerves were quite anæsthetic for several months after the operation, but now she knows that one touches her and the parts feel "quite numb" or, as the patient prefers it, "quite deadified." There was never any motor paralysis.

REMARKS.

Perhaps it would have been much wiser if I had done the operation in two stages, as Horsley recommends in any serious intracranial operation, instead of attempting it in one stage as is advised by Krause in this particular operation. Although the whole operation only took an hour and five minutes, there being very little trouble in exposing and manipulating the outer half of the Gasserian ganglion, owing, I think, to the patient being dolichocephalic, still the shock proved to be rather serious, judging by the intermittency of the pulsation of the cerebral mass. There is no doubt that manipulation intracranially in these cases is more difficult in brachycephalic skulls owing to the increased depth of the ganglion from the surface. The Hartley-Krause method is comparatively simple compared with that of Rose, and the free removal of bone towards the base with rongeur forceps, and the free use of Horsley's wax over the cut bone, saves much time.

At present the dépression in the temple seems very firm and non-pulsatile, and I do not think that an osteoplastic flap of the skull in this region is worth the making with its risk of dividing the middle meningeal artery in the bone, and so causing an unnecessary loss of blood before the bone flap is turned down, and also the risk in the future failure of the bone performing what is expected of it; with a $\frac{1}{4}$ -inch trephine and a pair of rongeur forceps one can expeditiously and with safety make the necessary opening as low as possible towards the base of the skull. The middle meningeal artery running to the foramen spinosum caused no trouble in this case.

An elaborate and valuable paper by Louis McLane Tiffany deals with 108 cases of intracranial operations for the cure of facial neuralgia, and most of the points of interest in those cases are fully considered in the *Annals of Surgery*, November, 1896.

The sensory condition of the face in my case before the operation suggested that the cause of the neuralgia was distal to the Gasserian ganglion, because there were no analgesia and blunting of the sense of heat in the distribution of the ophthalmic division of the fifth; one would hardly expect a primary pathological condition of the Gasserian ganglion itself to be so territorially limited as to cause a neuralgic distribution of pain to two or one only of its main efferent branches; nevertheless, the second and third branches are the ones most commonly affected, and hence, in all probability, when disease of the ganglion exists in such cases, it is due to extension from the affected nerves.

It is but rarely that an intracranial operation has been done for neuralgia without the previous performance of one or more peripheral operations, but in this case it seemed to me that there would be more shock and greater difficulties in doing the necessary peripheral operations than at once to do what I decided upon.

The bleeding which prevented my completing the operation was probably from the small meningeal artery by the side of the inferior maxillary nerve, and I think I am justified in stating that had I completely divided the nerve without the bleeding there would not have been any recurrence of pain along the inferior dental nerve. Had the patient allowed me to operate the second time I should have attempted the division of the inferior maxillary nerve and ganglion by a fine electro-cautery, whilst the nerve would be held taut by a fine hook; by this means I hoped to avoid bleeding, and the sudden yielding of the hooked nerve would indicate complete division.

If Dr. Williams had not notified me of the intermittency of the cerebral pulsation I should have continued the operation, and possibly might have overstepped the operative tolerance of my patient, hence my concluding remark is like the first one: perhaps it would have been much wiser if I had done the operation in two stages, as Mr. Horsley advises.

My thanks are due to Dr. Williams for his vigilance whilst giving the anæsthetic, and to Mr. Morland for assisting me at the operation.

FRAGILITAS OSSIUM:

NOTES ON THE HISTORY OF A FAMILY IN WHICH IT APPEARS TO BE HEREDITARY.

By J. HUNTER, M.B., C.M. GLASG.,
Senior House Surgeon, Macclesfield Infirmary.

On entering upon duty here as House-Surgeon there was a lad who had been admitted a few weeks previously with fracture of the femur. I discovered that he had broken his leg several times, and on further inquiry at his home obtained the following history:

At the age of 9 he fell about 7 feet, fracturing the right femur. Three years afterwards, when sliding, he fell and fractured his right femur. Two years later, when playing football, he fell and fractured the left femur. Two years later still he was knocked down when playing football, and fractured the right femur.

He has a sister who fell while playing, eight years ago, and broke the left femur.

Another sister fell a few feet and broke her right femur.

She and her brother were dismissed on the same day from the infirmary with the fractures completely united. On the way home she rested her back against a door, which gave way, and she fell, fracturing the left femur this time.

Another brother sustained a fracture of the right femur when playing. About two months after, on being lifted out of bed and placed on the floor, his foot caught the leg of a table near, breaking the femur again at the same point evidently, as the limb, which was everted after the previous fracture, became straight again on union taking place.

His father has had several fractures, four of the right and three of the left femur. The first occurred at the age of six months, the last nine years ago. He is 50 years of age, and states that he has always had good health. He is about 4 feet 10 inches in height, with marked disproportion between the length of his body and limbs. There is some deformity, with considerable shortening of both femurs, the right being about 2 inches shorter than the left. The remainder of the family, aged 15, 6, and 2 years respectively, have never sustained any fracture, and with the exception of the youngest seem to be in good health. The grandfather is still living, and states that none of his relations ever suffered in the same way.

I consider the above history rather interesting, as the family seem healthy, and there is nothing to indicate any particular diathesis. The seat of fracture seems to be always about the junction of the middle and upper thirds, and the degree of violence necessary to produce one is comparatively slight. Union is complete after the usual period has elapsed.

MULTIPLE PAPILLOMATA OF THE LARYNX IN YOUNG CHILDREN TREATED BY TRACHEOTOMY ONLY.

By T. C. RAILTON, M.D. LOND., M.R.C.P.,
Physician to the Children at the Manchester Clinical Hospital for
Women and Children.

CASE I.—CURE AFTER WEARING A TUBE FORTY-FIVE MONTHS.

DOROTHY S., a girl aged 3 years and 3 months, was brought to the hospital on February 13th, 1894, with well-marked symptoms of laryngeal obstruction, including stridor during inspiration and expiration, inspiratory recession of the chest walls, chronic hoarseness, and a frequent croupy cough. At times she was quite voiceless. Her parents were healthy, and had no other children. The patient's hoarseness had been observed for nearly two years, and an attack of whooping-cough six months previous to her admission had aggravated it considerably. Latterly she had suffered from alarming attacks of dyspnoea in the night time, and these had induced her parents to seek medical aid. The diagnosis of multiple papilloma of the larynx was arrived at in spite of the fact that repeated attempts had failed to obtain a view of the larynx, on account of the smallness of the space available and the restlessness of the patient, but

the opinion was subsequently confirmed by the appearance of growths at the wound, sprouting round the tracheotomy tube. On several nights after her admission the child suffered from serious attacks of dyspnoea, accordingly tracheotomy was performed by my colleague, Mr. Southam on February 23rd with an immediate relief of all the urgent symptoms.

A week after the operation the silver tube which had been used was replaced by a soft rubber one, and this kind of tube (changed three times a week) was worn from that date until November 16th, 1897, when it was finally removed—a period of 3 years and 9 months—and the opening was then allowed to contract and was ultimately closed by a small plastic operation on December 16th.

The diagnosis of papilloma of the larynx was verified, as I have said, by the appearance at the tracheotomy wound some six months after the operation of growths sprouting round the tube. These were shaved off, and small doses of arsenic were administered internally. With the exception of a slight recurrence eight months later, which was similarly dealt with, there has been no drawback to the child's perfect recovery. The voice and breathing were observed at intervals during the wearing of the tube (by temporarily closing the opening), but it was not thought advisable to remove it until every trace of stridor or hoarseness had disappeared. The tube produced no inconvenience beyond the tendency it caused for the child to take cold easily. The larynx has recently been examined by Mr. Larmuth, who pronounces it to be perfectly healthy. Both breathing and voice are absolutely normal.

CASE II.—CURE AFTER WEARING A TUBE TWENTY-FIVE MONTHS.

Frances G. L., a girl of 4 years, was brought to the hospital on March 29th, 1894, with a history of chronic hoarseness, noisy breathing and croupy cough, with paroxysms of dyspnoea coming on at night. Her parents and four other children were said to be healthy. Two other children had died from croup.

On admission it was observed that she had inspiratory stridor with marked recession of the chest walls (suprasternal and supraclavicular regions and slightly at the ensiform cartilage and outwards). She was very hoarse and had a hoarse cough which was very troublesome. During the night the breathing became more difficult, but there were no paroxysms of dyspnoea. She was examined with the laryngoscope by Mr. Larmuth, and at the third attempt he was able to see warty growths projecting from the ventricle of the larynx and other masses coming between the true cords.

Tracheotomy was performed by Mr. Southam on May 9th and a rubber tube was worn until June 5th, 1896, when all traces of obstruction having disappeared, and the voice having regained its natural clearness, it was finally removed.

Mr. Larmuth has recently examined the larynx for me and finds that after a lapse of eighteen months there is not the slightest symptom of the recurrence of the disease.

REMARKS.

It was determined at the beginning of the treatment of these cases to limit it to tracheotomy, the more radical operations of thyrotomy or endolaryngeal extirpation having proved so very unsatisfactory in children, even at the hands of the most skilful operators. It would appear that the spontaneous atrophy of the papillomata depends upon the removal of all causes of irritation in breathing and more particularly in coughing. I do not attach much importance to the effect of the arsenic administered in the first case, in the second none was given.

I must acknowledge my indebtedness to Dr. G. Hunter Mackenzie's communications¹ for the idea of depending upon tracheotomy alone.

REFERENCES.

¹ *Edinburgh Med. Journal*, 1884; *Lancet*, April 6th, 1889; and *BRITISH MEDICAL JOURNAL*, September 12th, 1896.

THE METRIC SYSTEM.—The *Pharmaceutical Journal* announces that with the view of encouraging and assisting the general adoption of the metric system of weights and measures by pharmacists, all quantities will in future be given in its pages in accordance with the metric system.

A CASE OF CHRONIC INTUSSUSCEPTION.

By J. ORTON, M.R.C.S., L.R.C.P.LOND., D.P.H.EDIN.,
Foleshill, near Coventry.

J. K., aged 58, first seen November, 1893, was then complaining chiefly of the extremely offensive character of his motions, and of pain located over the caecal region. The offensiveness of the stools had first been noticed in the early part of the summer, and it had gradually become more intense, and was accompanied by some amount of pain on straining at stool. On examination of the abdomen, a soft, doughy mass was felt in the iliac fossa, which was thought to be faecal, and disappeared with enemata, without, however, benefiting the pain, which seemed gradually to increase in severity in spite of a careful dietary and drug treatment. Chronic typhlitis with ulceration was diagnosed, and consultation with several other medical men failed to improve upon this diagnosis.

As all palliative treatment had little effect in mitigating his condition operative treatment was discussed, but the possibility of the disease being malignant did not seem to justify its strong recommendation, and the patient did not give his consent. The condition, however, became worse. The pain would cease perhaps for a day or two, only to recur with renewed vigour, and he continued to lose weight. Nothing abnormal, however, was to be found on palpation of the abdomen; the bowels acted fairly regularly, a loose motion being passed, occasionally streaked with blood. The intermissions of rest from the pain, however, became fewer and fewer, and he died from exhaustion in November, 1896, after an illness which had lasted three years and a half, having been for the last six months or so almost constantly under the influence of morphine. As he had expressed a decided wish during his lifetime for a *post-mortem* examination to be performed, this was done the day succeeding his death. The body was very emaciated, the abdomen retracted, and on opening the latter no caecum was to be found in the right iliac fossa. This, together with the ascending, transverse, and descending colons were all involved, together with a great portion of the small intestine, in an intussusception which filled up the left side of the pelvis, and extended to the first part of the rectum. The condition was so chronic that it was impossible to reduce the intestines, the adhesions being so very firm; part of the invaginated portion had become but a fibrous coat. On following up the narrow lumen of the canal with scissors, the part corresponding to the caecum was found to be occupied by a gangrenous, ulcerated mass, the size of a small egg, which had no doubt given rise to the offensive stools.

REMARKS.

The case seems worthy of being reported chiefly on account of the probable great length of time that the intussusception had been forming, and of the large extent of intestine involved without gangrene of any portion taking place. It is hard to say when the intussusception commenced, but it certainly must have extended over many months, as evidenced by the tough, fibrous condition of the tube. The primary mischief was doubtless the chronic inflammation and ulceration of the caecum, which first became invaginated and gradually involved the other parts, and the patient only died very slowly from exhaustion.

SOME CASES OF PELVIC SUPPURATION IN THE FEMALE.

By JAMES OLIVER, M.D., F.R.S.EDIN., F.L.S.

The following cases which have occurred in my practice appear to me to present features of interest:

CASE 1. *Abscess of Ovary: Symptoms Developing One Month after Parturition: Operation: Recovery.*—A. M., aged 28, and married six years; has had three children, and no miscarriage; the last child was born four months ago. This child was not suckled. The menstrual discharge reappeared 24 months after this confinement, and on this occasion it was slightly excessive, but in the following month it was of the usual amount. One month after the last confinement the patient was seized with severe pain in the lower abdomen and back, and during the twenty-four hours succeeding the onset of this attack the catheter had to be used twice, as there was complete retention of urine. Thereafter, and up to the present time, some difficulty has been experienced in voiding urine, and the act has always been accompanied with severe pain. Since the attack, one month